An Update of Hawaii QUEST's Medical Plans' Performance, Using HEDIS Measures, 1997-1998

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What is HEDIS 3.0/1998?

Since the inception of the QUEST program, participating health plans have been reporting Health Plan Employer Data and Information Set (HEDIS[1]) performance measurements. In the previous two state fiscal years, QUEST health plans were required to submit *Medicaid 2.0/2.5* measures to the Med-QUEST Division[2] (MQD) for an annual quality assessment of health care services. In May 1998, the QUEST Medical Directors and the MQD made a joint decision to adopt technical and format specifications outlined in *HEDIS 3.0/1998,* as the basis of HEDIS reporting requirements by health plans for the 1998 state fiscal year.[3] *HEDIS 3.0/1998* is the third version of HEDIS released by the National Committee for Quality Assurance (NCQA) — a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans. *HEDIS 3.0/1998* was designed to provide the same measurement standards between Medicaid beneficiaries, commercial enrollees and Medicare risk populations. This is the first attempt to measure and compare public and private managed care populations objectively and efficiently.

What is measured in HEDIS 3.0/1998?

HEDIS 3.0/1998 contains over 50 measures,[4] organized in the following eight (8) reporting categories or domains:

- Effectiveness of Care;
- Access/Availability of Care;
- Satisfaction with the Experience of Care;
- Health Plan Stability;
- Use of Services;
- Cost of Care;
- Informed Health Care Choices; and
- Health Plan Descriptive Information.

Health plan performance for all the above categories is reported as tables. The Effectiveness of Care domain assesses the impact of care delivered to certain segments of plan membership. Generally, the measures apply to members continuously enrolled for 12 months with a maximum lapse in coverage of 45 days. Access/availability of care measurements relate to the availability of services to plan members.

The Satisfaction with the Experience of Care domain assesses how members view the plan in meeting their health care needs and expectations. Health Plan Stability measures look at the stability of a health plan and any changes that could disrupt care to its members. Next, the Use of Services domain provides information on utilization of resources, and the Cost of Care measures evaluate the overall cost to the plan and rate trends to plan members.

Then, the Informed Health Care Choices domain looks at how well the plan assists members to remain active in health care planning and to make informed choices about treatment options. Finally, Health Plan Descriptive Information and Use of Services measures relate to all members in the plan.

What categories must QUEST plans report?

The QUEST medical plans must report measures relating to Effectiveness of Care, Access/Availability of Care, Health Plan Stability, Use of Services, and Health Plan Descriptive Information. Since all QUEST plans must submit a yearly financial statement, and the MQD conducts an annual customer satisfaction survey, medical plans were not required to report *HEDIS 3.0/1998* categories relating to Cost of Care, and Satisfaction with the Experience of Care. The Informed Health Care Choices domain currently does not contain any measures in the reporting set.

What should be considered in reviewing QUEST HEDIS 3.0/1998?

The information presented is an aggregation of data submitted by individual QUEST medical plans with complete reports. Since *HEDIS 3.0/1998* specifications allow for data collection using various specified methodologies, the QUEST plans may select different allowable methodologies to report the same measure. Therefore, differences in data sources and data collecting methodologies may affect the validity of the aggregate data presented. Additionally, while the QUEST plans reviewed their individual reports and verified their data prior to submission, the MQD does not audit each plan's data. However, the MQD executes a strict protocol to examine the contents for accuracy and consistency. QUEST plans here must justify or rerun specific measures, based on the MQD's review.

What HEDIS 3.0/1998 measures are reported?

The QUEST plans reported a total of 38 mandatory measures under

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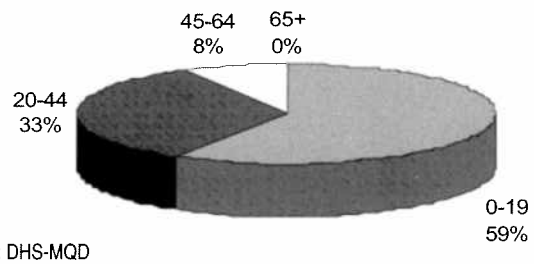
HEDIS 3.0/1998. The collection of these measures is available from the MQD.[5] This narrative report focuses on ten (10) key measures which are frequently used in assessing a medical plan's performance in providing quality care:

1. Membership by Age and Sex;
2. Childhood Immunization Status;
3. Cervical Cancer Screening;
4. Prenatal Care in the First Trimester;
5. Low Birth-Weight Babies;
6. Eye Exams for People with Diabetes;
7. Follow-up After Hospitalization for Mental Illness;
8. Children's Access to Primary Care Providers;
9. Outpatient Drug Utilization; and
10. Inpatient Utilization - General Hospital/Acute Care.

Exhibit 1



Source: DHS-MQD

I. Membership by Age and Sex

Why is this important?

This measure provides a demographic profile of the QUEST population and answers general questions about people who are receiving their health care services from QUEST.

What was measured?

The unduplicated count and member months of QUEST members by age and sex, enrolled during any part of the reporting year (July 1, 1997 to June 30, 1998) were recorded.

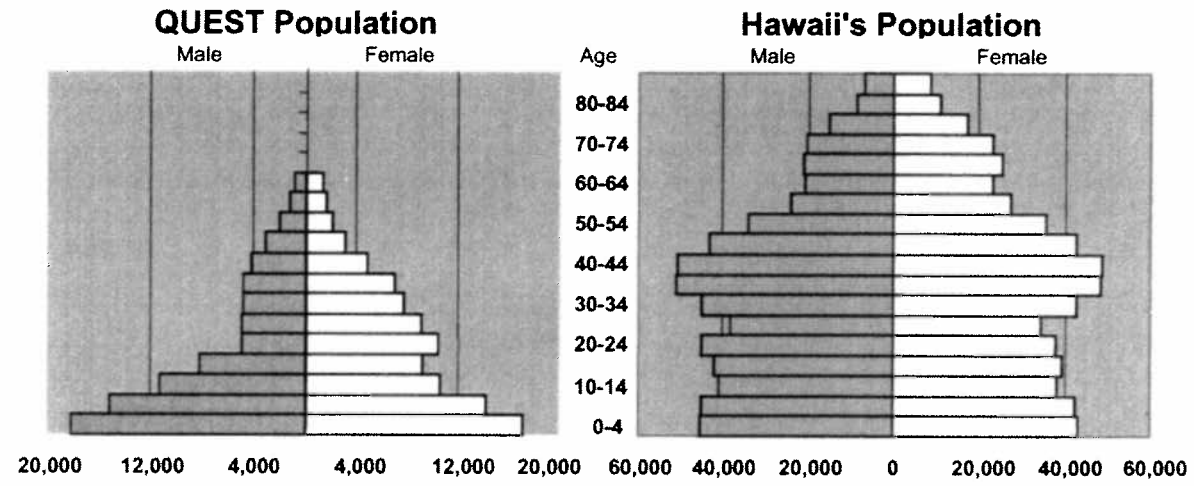
How did QUEST perform?

Enrollment in the QUEST program has stabilized, recording 182,902 members in fiscal 1998, compared to 180,684 members in fiscal 1997, and 192,296 members in fiscal 1996. The QUEST population in fiscal 1998 was also the youngest in three consecutive years. The mean age of QUEST members dropped to 19.8 years in fiscal 1998, from 20.1 years in fiscal 1997, and 21.3 years in fiscal 1996.[6] QUEST members remain predominantly children and women. Approximately 57 percent of total membership in fiscal 1998 were children under 20 years of age, up one (1) percent from the previous year. The proportion of children in the program is even higher, when counting by member months. The HEDIS member months measure indicated that approximately 59 percent of total member months in fiscal 1998 were accounted for by children under 20 years of age. The 20-44 years, age cohort, accounted for another 33 percent of all member months in fiscal 1998. Exhibit 1 summarizes the distribution of member months by selected age cohorts.

Another useful demographic approach is to evaluate the age and sex distribution of a population for a given fiscal year, and then summarizing it graphically with a "population pyramid." A population pyramid displays the distribution of male and female members in different age groups. Exhibit 2 below shows the QUEST population structure in fiscal 1998, as compared to Hawaii's resident population in July 1997.[7] The QUEST population displays a skewed, classic "pyramid", with a large proportion of younger people, fewer middle-aged people, and far fewer near-elderly people. There is also a disproportionate cohort of middle-aged women.

In contrast, the Hawaii resident population structure resembles a

Exhibit 2



Sources: DHS-MQD and DBEDT

bulging "pillar." This is a more mature population, with proportionately fewer young people (ages 0-29) contributing to the total. The middle-aged group (ages 30-49) is the dominant segment of this population structure while the near-elderly (ages 50-64) and elderly (ages 65 and over) groups appear rather significant, before tapering off. The difference between the Hawaii population structure and that of QUEST for the elderly cohort can be explained by current QUEST eligibility requirements, which preclude enrollment of individuals over 65 years of age. Elderly individuals, qualifying for Medicaid, are enrolled in the fee-for-service (FFS) program.

II. Childhood Immunization Status

Why is this important?

Immunization in the first two years of life is accepted as one of the most effective public health measures in preventing serious illnesses such as whopping cough, polio, measles, and hepatitis B. Unfortunately, studies have shown that low-income children are less likely to receive timely immunizations. In 1990, the Centers for Disease Control (CDC) reported that less than 50 percent of low-income, inner city children were fully immunized by age two.

What was measured?

In QUEST, the childhood immunization rate is the percentage of two-year olds who were enrolled in one plan for 12 months, and who had received appropriate immunizations by their second birthdays. (A break in enrollment not to exceed 45 days was allowed.)

How did QUEST perform?

QUEST did relatively well when compared to the previous year, and to rates reported in other studies. The childhood immunization rate was 75.2 percent in fiscal 1998, marginally lower, compared to 77.4 percent in fiscal 1997 but much higher than the 62.5 percent rate in fiscal 1996 (see Exhibit 3). The rate in fiscal 1998 would likely be higher, if not for delays in plan changes, arising from a contractual dispute/negotiated settlement between the State and the medical plans. An estimated, 800 beneficiaries, under two (2) years of age, on Maui and Kauai were required to switch medical plans, two months into the fiscal year. Consequently, these children were not counted in many HEDIS measures because they did not qualify for 12 months of continuous enrollment, in any one plan.

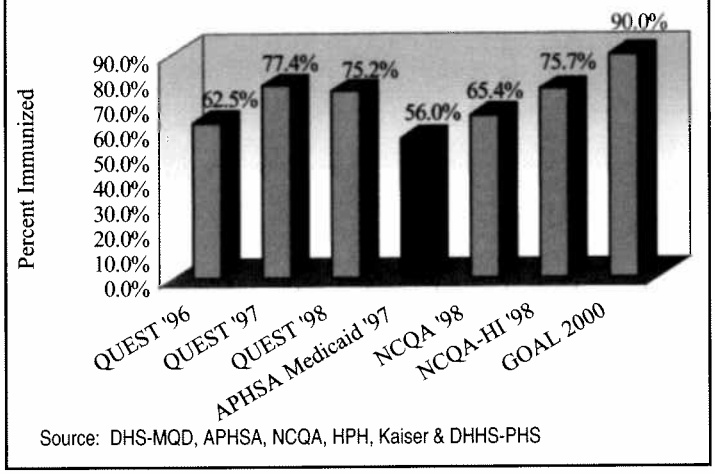
Despite the slightly lower immunization rate in fiscal 1998, the QUEST plans comfortably beat two important national averages. The NCQA released its second annual edition of "The State of Managed Care Quality." This report collected information voluntarily submitted by 447 managed health plans, covering 60 million Americans throughout the United States. The NCQA reported that the national average rate of children who had received 4 DPT/DTaP (diptheria-tetanus-pertussis), 3 polio (OPV/IPV), 1 MMR (measles-mumps-rubella), 1 Hib (H influenza type b), and 2 HepB (Hepatitis B) was 65.4 percent for all health plans which submitted data.[8] The QUEST plans exceeded this national average for commercial plans as reported by the NCQA.

Secondly, the American Public Human Services Association (APHSA) also issued its newly created "benchmarks" on selected *Medicaid HEDIS* measures.[9] This new set of nine (9) measures were calculated from information submitted by 111 health plans, spread across 18 states, participating in this pioneer project. The QUEST plans exceeded the national rate of 56 percent as reported by the APHSA.

In addition, the QUEST plans' rate came close to the average rate for Hawaii's two NCQA accredited managed care plans.[10,11] The two commercial plans' reported an average rate of 75.7 percent. Finally, retrospective studies done in Hawaii on children entering kindergarten have shown that between 58-63 percent received the basic series by age 2.

The "Healthy People 2000" goal is to increase to 90 percent the proportion of children up to 2 years of age who are fully immunized.[12] "Healthy People 2000" is a set of national health promotion guidelines and disease prevention objectives, managed by the U.S. Public Health Service (DHHS-PHS).

Exhibit 3



Source: DHS-MQD, APHSA, NCQA, HPH, Kaiser & DHHS-PHS

III. Cervical Cancer Screening

Why is this important?

In 1994, approximately 15,000 new cases of cervical cancer were diagnosed and 4,600 women in the United States died from the disease. Additionally, the rate of cervical cancer is higher among minority and economically disadvantaged women, and they are more likely to be diagnosed when the cancer is in advanced stages. Fortunately, cervical cancer is curable if detected early by regular check-ups and use of the Papanicolaou (Pap) smear test. Thus, for QUEST women, cervical cancer screening is very important and saves lives.

What was measured?

The cervical cancer screening rate is the percentage of women, ages 21 to 64, enrolled in one plan for 12 months, who had at least one Pap smear during the past three years.

How did QUEST perform?

The QUEST plans did not report this measure in fiscal 1996. In fiscal 1995, the reported rate was 33.8 percent. The 1995 rate was for the first eleven (11) months of QUEST, and was reported by four (4) of the five (5) plans. Furthermore, the plans did not have three years worth of data as required by the measure.

In fiscal 1998, the screening rate reported was 65.4 percent, down from 70.2 percent in the previous year. The lower screening rate reported is attributed to several factors. First, there was the delay in plan changes, which disqualified many female beneficiaries from satisfying the 12 months of continuous enrollment. Second, the definition of women included in the measure was changed to 21-64 years of age in *HEDIS 3.0/1998* from 16-64 years in *Medicaid HEDIS*. Given the large number of QUEST beneficiaries in the younger age range, the change in definition resulted in fewer women being counted in the measure. Third, a major medical plan made methodology changes to the measure, which resulted in a much lower rate. As a consequence of the above factors, the number of eligible beneficiaries was lower compared to the previous year. The increase in days allowable for satisfying continuous enrollment from 30 to 45 did not appear to have any noticeable impact on this measure.

Despite these shortcomings, the QUEST plans' screening rate exceeded the national Medicaid average of 63 percent as reported by the APHSA (see Exhibit 4). It was also close to a timely released NCQA study which reported a 71.3 percent national average for women ages 21 to 64 in participating health plans. The average rate for Hawaii's two NCQA accredited managed care plans was identical to QUEST at 71.3 percent. The "Healthy People 2000" goal is to have 85 percent of women receive a Pap smear every one to three years.

IV. Prenatal Care in the First Trimester

Why is this important?

Timely, thorough and adequate prenatal care in the first trimester can effectively help reduce a mother's likelihood of delivering a low birth-weight infant. Likewise, early prenatal care can help to detect and address maternal health problems early in the pregnancy. Medical problems are often easily corrected when detected and treated early. Otherwise left untreated, they may threaten the health of both mother and unborn child.

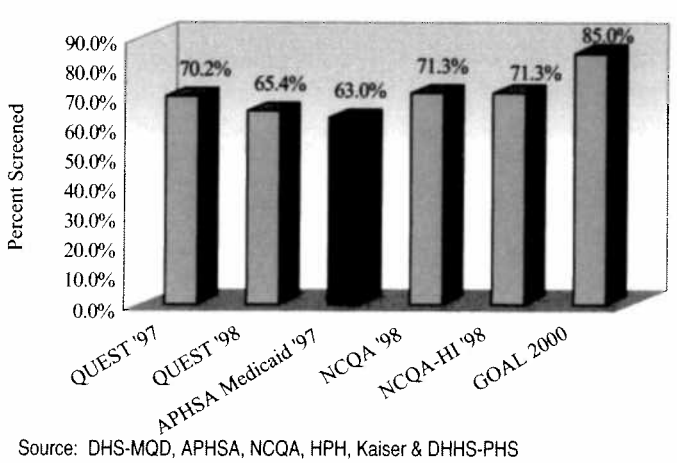
What was measured?

The prenatal care rate is the percentage of women who delivered a live baby, and had received prenatal care in the first three (3) months of pregnancy.

How did QUEST perform?

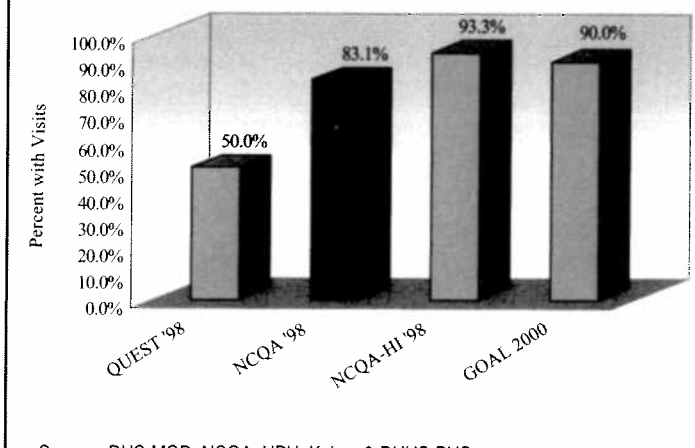
This measure was used for the first time by QUEST plans. The QUEST rate was 50 percent, compared to the NCQA's average of 83.1 percent. Exhibit 5 illustrates QUEST's performance with other important benchmark measures. The lower rate for QUEST is not an attribute of poor performance. Rather, it is a manifestation of the measure and compounded by the unique characteristics of the QUEST program. Pregnant women are eligible up to 185 percent of the Federal Poverty Level (FPL) and assets are not counted (non-payment applies to individuals under 100 percent of the FPL and they are subject to limited assets). Therefore, many women apply to the QUEST program after they become pregnant. Despite an expedited eligibility and enrollment process at the time of enrollment, these women are often beyond their first trimester. Hence, these eligible women with eventual live births were counted in the denominator, but they have no recorded prenatal care visits for the first trimester, as measured in the numerator. Consequently, the measure is biased downwards. Despite QUEST's performance in this measurement, eligible pregnant women do have access to prenatal care. Many pregnant women, eligible for QUEST and pending enrollment into a medical plan, have access to prenatal care through services covered under the fee-for-service (FFS) Medicaid program. Unfortunately, those FFS visits are not included in the HEDIS report.

Exhibit 4



Source: DHS-MQD, APHSA, NCQA, HPH, Kaiser & DHHS-PHS

Exhibit 5



Source: DHS-MQD, NCQA, HPH, Kaiser & DHHS-PHS

V. Low Birth-Weight Babies

Why is this important?

Low birth-weight infants face higher risk for chronic and permanent disabilities, serious medical complications and illnesses, and death in infancy. Low-income women are typically at higher risk for having low birth-weight infants. There are many factors that can increase a woman's risk of having low birth-weight infants. Some of the more common factors include smoking, poor nutrition and chronic medical conditions. Many of these risk factors can be managed by timely and comprehensive prenatal care. Careful management of women at high risk for premature delivery can reduce the possibility of having an underweight baby.

What was measured?

The percentage of low birth-weight (less than 2,500 grams or 5.5 pounds) babies born during the fiscal year was measured using hospital discharge data or birth certificate data.

How did QUEST perform?

In fiscal 1998, the low birth-weight rate for the QUEST population dropped to 5.2 percent from 5.8 percent in the previous year. Exhibit 6 shows the QUEST plans performed very well in this measure compared to its commercial peer, and is very close to the Healthy People 2000's goal of 5.0 percent. In this measure, a lower percentage rate of low birth-weight infants is desirable. The QUEST plans' low birth-weight rate of 5.8 percent in fiscal 1997 was also better than the statewide rate of 6.7 percent, reported by Hawaii's Department of Health.

VI. Eye Exams for People with Diabetes

Why is this important?

Diabetes mellitus affects approximately 6.5 percent of Hawaii's population and is the leading cause of severe eye damage and adult blindness in the United States. However, blindness may be prevented if retinal changes are detected early, and treated appropriately with laser. Therefore, early intervention through effective screening is crucial in preserving the eyesight of individuals with diabetes.

What was measured?

The diabetic eye exam rate is the percentage of diabetic adults, ages 31-64, who received a retinal (eye) exam in the past year.

How did QUEST perform?

Although the QUEST plans' rate of 40.2 percent in fiscal 1998 was slightly lower compared to 42.6 percent recorded in fiscal 1997, it nevertheless, exceeded the NCQA national average of 39 percent. The slightly lower rate in fiscal 1998 is statistically more robust, considering that five plans reported the measure compared to only two plans reporting in fiscal 1997 (then an optional measure for QUEST plans). Exhibit 7 shows the rate for different populations. Despite a credible performance in its first plan-wide reporting, QUEST trails behind the 54 percent, average rate for NCQA accredited managed care plans in Hawaii.

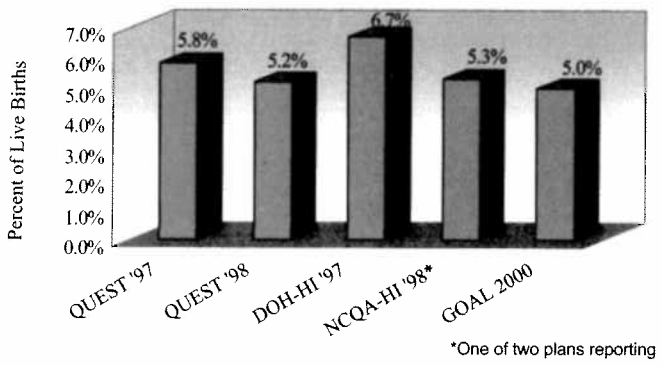
VII. Follow-up After Hospitalization for Mental Illness

Why is this important?

The National Institute for Mental Health (NIMH) has reported that a significant percentage of individuals experience some form of mental illness, including manic depression, paranoia and schizophrenia. However, only a small proportion of these individuals is medically diagnosed. Suicide, the most serious risk to those with mental illness, caused 15 percent of the deaths associated with untreated mood disorders. Those deaths may occur, four to five years after the first clinical episode.

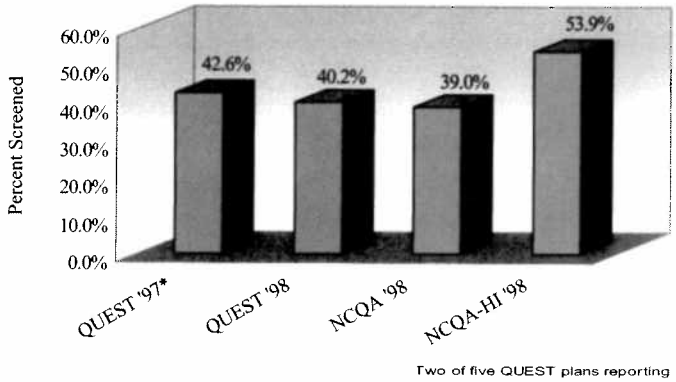
It is therefore important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health provider within 30 days of discharge is important for the orderly transition to the home or work

Exhibit 6



Source: DHS-MQD, DOH, NCQA & DHHS-PHS

Exhibit 7



Source: DHS-MQD, NCQA, HPH & Kaiser

environment. Such a visit would also help the mental health provider to track the effectiveness of prescribed drug therapies or to detect any possible post-hospitalization reactions.

What was measured?

This particular measure estimates the percentage of members, hospitalized for treatment of a major affective disorder and were seen by a mental health provider within 30 days of discharge.

How did QUEST perform?

In fiscal 1998, the number of beneficiaries receiving follow-up after hospitalization for mental health continued to increase. In fiscal 1997, the follow-up rate was 53.1 percent. In fiscal 1998 the rate increased to 56.2 percent. Exhibit 8 shows the QUEST rate was rather low compared to the NCQA national average of 72.3 percent. However, the QUEST plans exceeded the average rate of 51.6 percent for NCQA accredited managed care plans in Hawaii. The lower rate for the QUEST plans may be the result of the seriously mentally ill (SMI) adults, who are enrolled in a separate QUEST behavioral managed care "carve-out" plan called Community Care Services (CCS). Data from CCS was not included in the HEDIS report.

VIII. Children's Access to Primary Care Providers

Why is this important?

Opponents of managed care often claim that members have a difficult time obtaining appropriate health care services in a timely manner. There is an ongoing concern about access to the existing health delivery system, and especially, in a time of need. In general, children are more susceptible to illnesses or injuries arising from accidents, and hence have a greater propensity to require health care services. Additionally, children accounted for 57 percent of total QUEST membership. Hence, visits to pediatricians, family physicians, and other primary care providers is an indicator of general access to health care services for children.

What was measured?

The proportion of children in QUEST who registered a visit with a health plan primary care provider during the reporting year was measured. (A break in enrollment of up to 45 days was allowed.) Measurements were recorded for three separate groups of children: (i) infants (age 12 months to 24 months); (ii) pre-schoolers (age 25 months to 6 years); and (iii) pre-teens (age 7 years to 12 years).

How did QUEST perform?

QUEST's performance was mixed in this measure. The children's access rate to primary care providers in QUEST were 90 percent for infants, 80 percent for pre-schoolers, and 76 percent for pre-teens (see Exhibit 9). The QUEST plans exceeded the national Medicaid average, as reported recently by the APHSA in every category. However, in comparison to NCQA accredited managed care plans in Hawaii, QUEST could only match the former's rate in the infant category. In both the pre-schooler and pre-teen categories, QUEST lagged some 13-14 percentage points behind. We believe QUEST performance in this measure will improve in future. In this reporting year, one QUEST plan reported lower than expected rates, which subsequently reduced the overall rates.

IX. Outpatient Drug Utilization

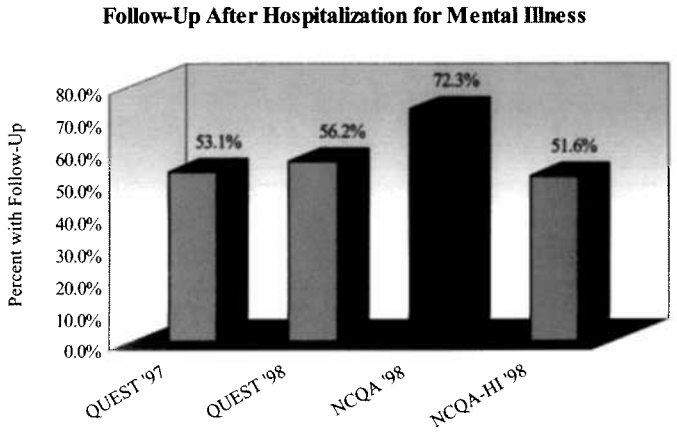
Why is this important?

This measure summarizes data on outpatient utilization of prescription drugs by age group. Hence it assists medical plans and the MQD to assess how cost effective the QUEST drug benefit is being administered.

What was measured?

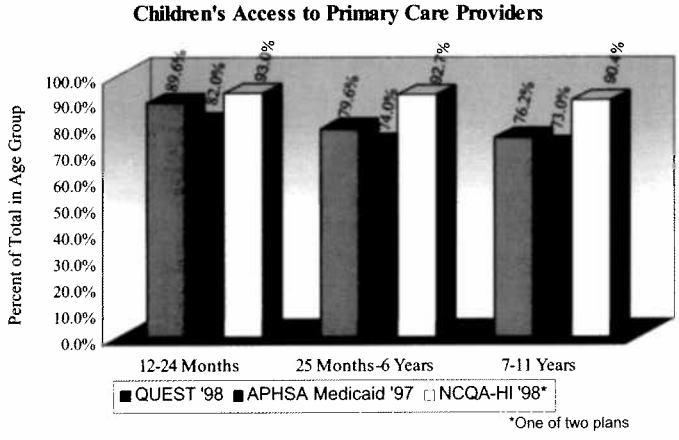
Some information reported in this measure include the total cost of prescription drugs, the average cost per member per month, the total number of prescriptions filled, and the average number of prescrip-

Exhibit 8



Source: DHS-MQD, NCQA, HPH & Kaiser

Exhibit 9



Source: DHS-MQD, APHSA & HPH

tions filled per year for QUEST members of different ages.

How did QUEST perform?

In fiscal 1998, the cost per member per month (PMPM cost) of the QUEST prescription drugs increased to $13.47, an increase of 12 percent from $12.03 in the previous fiscal year. The average number of prescriptions filled also increased from 7.7 prescriptions PMPM in fiscal 1997 to 8.2 prescriptions PMPM in fiscal 1998. The higher utilization rate and higher market price of prescription drugs during the year were primarily responsible for the higher overall drug costs. This marks a turnaround of the downtrend in QUEST drug costs in the previous two years.

Despite the upward bias in drug costs, Exhibit 10 shows that PMPM cost facing QUEST is still 7.5 percent below the average PMPM cost for NCQA accredited (commercial) managed care plans in Hawaii. The MQD feels that the lower average PMPM may be explained by the fact that QUEST plans have a younger population, of which 57 percent were children, with lower propensity for prescribed drugs as compared to an older population (with more chronic conditions). In addition, QUEST plans are allowed to develop their own formularies, subject to minimum requirements as established by the MQD. Furthermore, the NCQA commercial plans in Hawaii offer different drug benefits so their costs are not directly comparable with QUEST.

X. Inpatient Utilization - General Hospital/Acute Care

Why is this important?

Acute inpatient care in hospitals is one of the most costly expenses of a medical plan. It is therefore important for medical plans to monitor for excessive utilization of inpatient services or likewise for an insufficient level of care.

What was measured?

The total number of QUEST enrollees who received acute inpatient care in hospitals and the category of care they received (medical, surgical and maternity) by age were measured. Non-acute care, mental health, chemical dependency and newborn care services were excluded. This measure is expressed as discharges per 1,000 member months. The total number of hospital days by category of care and the average length of stay (ALOS) were also reported.

How did QUEST perform?

There were fewer discharges and fewer inpatient days reported in the 1998 fiscal year, which were consistent with a stabilized population in the QUEST program. The lower figures may also be associated with stricter data reviews and an improvement in claims processing procedures, as reported by some medical plans. The QUEST ALOS for total inpatient care remained unchanged at 3.4 days.

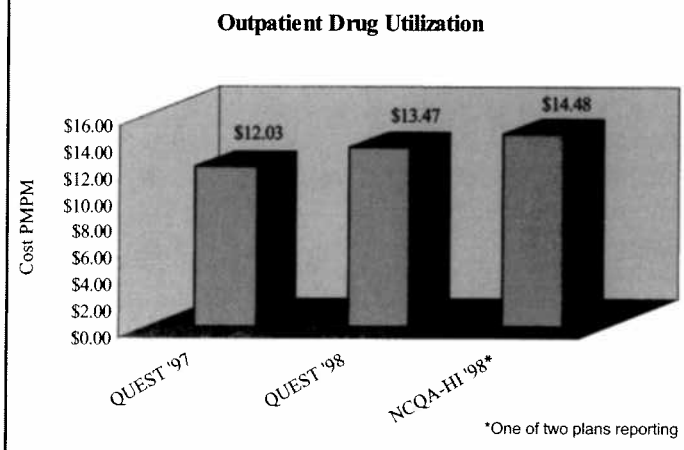
In the same fiscal year, the QUEST inpatient discharge rate was 7.2 discharges per 1,000 member months. This rate was lower than the hospital discharge rate of 7.7 per 1,000 member months for Hawaii State in 1997.[13] In contrast, the QUEST rate was higher when compared to Hawaii's NCQA accredited managed care plans. This higher rate is not unexpected, considering that QUEST has a higher proportion of expectant mothers, and consequently a higher frequency of maternity discharges.

Managed Care in QUEST

In September 1997, Kapiolani HealthHawaii became a QUEST health plan and immediately began providing services to approximately 10,700 eligible persons. With Kapiolani's participation, QUEST members were able to choose from six (6) QUEST medical plans. These medical plans are unique with six (6) different approaches to the delivery of medical care and six (6) different structures and organizational experiences. A summary description of the QUEST medical plans is as follows:

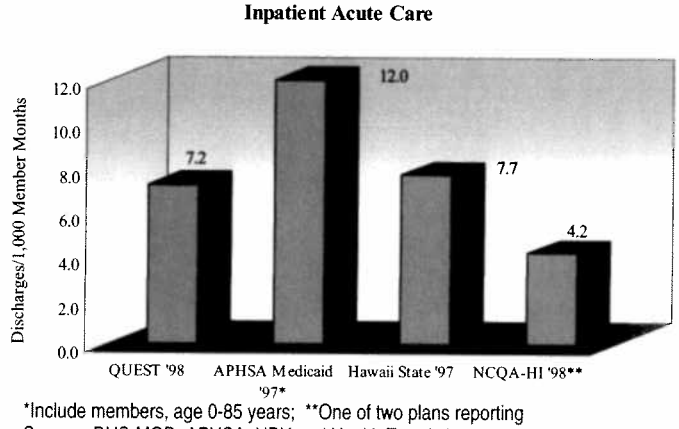
- **AlohaCare** is a plan, formed by local community health centers, and QUEST is its single line of business;
- **HMSA-QUEST** is a plan, owned by a local, non-profit, mutual

Exhibit 10



Source: DHS-MQD & HPH

Exhibit 11



*Include members, age 0-85 years; **One of two plans reporting
Source: DHS-MQD, APHSA, HPH and Health Trends in Hawaii, 1999.

benefit society, associated with Blue Cross/Blue Shield, with many commercial and government lines of business;

- **Kaiser Permanente QUEST** is a plan, owned by a large, nationally affiliated, non-profit Health Maintenance Organization (HMO);
- **Kapiolani HealthHawaii** is a plan, owned by a local, non-profit health care system, with close affiliation to a tertiary care hospital for women and children;
- **Queen's Hawaii Care** is a plan owned by a local, non-profit health care system with close affiliation to a comprehensive medical center; and
- **Straub Care Quantum** is a plan owned by a local, for-profit health care system.

Kaiser Permanente QUEST and **Straub Care Quantum** can be best described as "closed panel" medical plans because the care they provide is largely performed by staff physicians in their own clinics and facilities. **AlohaCare, HMSA-QUEST, Kapiolani Health Hawaii** and **Queen's Hawaii Care** are "open panel" medical plans which contract with health care providers to provide care at various sites, largely the providers' offices and facilities.

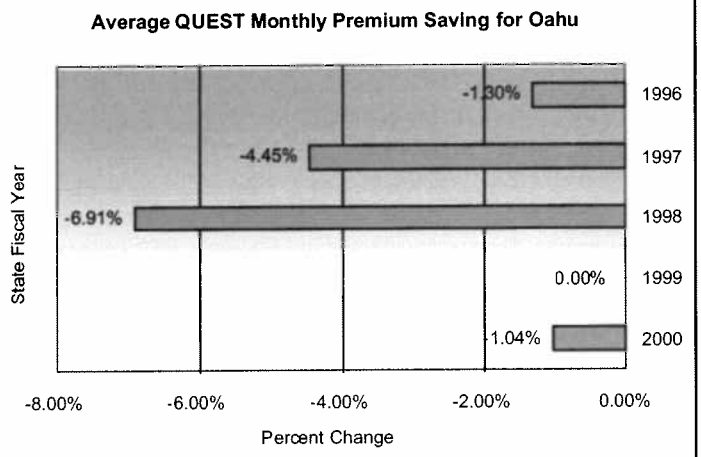
Despite their differences in structure and management styles, each QUEST medical plan utilizes managed care concepts in the provision of health care services to QUEST members. These key concepts include the application of case management, utilization management, new member orientation or education, and standards for waiting times.

Cost Containment in QUEST

Since the QUEST program was implemented in August 1994, there has been continuous premium saving being realized for each enrolled member. In the first fiscal year of operation, the premium saving was approximately 6.4 percent per member,[14] compared to equivalent payment under the fee-for-service (FFS) program. Thereafter, more premium saving was achieved in subsequent years. Reflecting this trend, Exhibit 12 shows the average QUEST monthly premium for Oahu. In the 1996 fiscal year, the monthly premium on Oahu was 1.3 percent lower than that in fiscal 1995. In both fiscal 1997 and fiscal 1998 contracting years, the QUEST program received more favorable premium saving. The QUEST monthly premium for Oahu dropped by 4.45 percent and 6.91 percent respectively. No premium saving was realized in fiscal 1999, due to the two-year contract reached in fiscal 1998.

In fiscal year 2000, a new, three-year contract with the QUEST medical plans, went into effect. The monthly premium saving on Oahu was 1.04 percent lower than the rate in the previous contract agreement (fiscal 1998). It is noteworthy that all premium savings over time have been realized without compromising quality health care services to QUEST enrollees. The QUEST annual customer satisfaction survey and selected HEDIS measures have strongly supported this contention. We believe that participating medical plans have made enormous progress in productivity gains and continuous quality improvements in both clinical and administrative areas. Five of the six existing plans in QUEST have been participating in the program since its inception in August 1994.

Exhibit 12



Source: DHS-MQD

Conclusion

Despite contractual changes in the 1998 fiscal year, QUEST's overall performance compares favorably with national and state benchmark measures in both commercial and Medicaid populations. The QUEST average (mean) was comparable, or exceeded national or state benchmarks, in seven of nine measures, discussed in this paper. Notwithstanding the demonstrated quality of care offered by QUEST in the current HEDIS report, continuous improvement opportunities exist in two measures — "Prenatal Care in the First Trimester" and "Follow-up After Hospitalization for Mental Illness." Under existing reporting guidelines, eligible, but not enrolled individuals and "carve-out" populations were excluded. Future efforts to include these populations will provide a more complete and accurate HEDIS reporting framework for QUEST. In addition, it may be useful to implement a rotation of HEDIS measures, so as to provide a broader base of quality indicators. However, one potential constraint remains. This relates to a lack of comparable benchmark data at both the national and state levels.

Finally, the reasonable quality of health care services provided to QUEST members has been achieved and maintained with lower monthly premiums over the years. As of July 1, 1999, the average monthly premium for Oahu has dropped by 13.1 percent since QUEST's inception in August 1994. This translates into a mean, nominal cost saving of 2.74 percent per annum. In contrast, the Consumer Price Index (CPI) for medical care in Honolulu has been rising steadily at the rate of 2.64 percent per annum during the same time period. If we were to consider the real (inflation adjusted) premium saving rate for QUEST on Oahu, it will average 5.38 percent, per year. This is a significant premium saving to QUEST. Thus far, the QUEST program has delivered an affordable, quality, health care system to its Medicaid population. Both the MQD and QUEST plans believe there is still room for improvement in productivity and quality innovations in management.

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highest number of donors in any year since inception of the organization in 1987 and 62% higher than the previous year (16 donors).

This survey indicates that physicians in Hawaii support organ donation and are aware of some of the current practices in this area. Various demographic data involve small numbers, so it is difficult to make any definite conclusions. It is interesting to note that a lower proportion of primary care physicians are organ donors compared to specialist physicians (41% vs 71%). Perhaps we need to explore this further and redouble our efforts at working with the primary care physicians. Although Hawaii physicians are supportive of organ donation, we must continue efforts at education of both the medical/hospital staff and the public. For it is with education, that the people of Hawaii will continue to benefit from organ transplantation.

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